Mission to Assess the Potential for Introduction of Evidence-based Family Planning Practices in Madagascar

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Acronyms

ADRA Adventist Development and Relief Agency International
AIDS Acquired immune deficiency syndrome
APQ [OJO NEED TO COMPLETE]
CBD Community-based distribution
CPR Contraceptive prevalence rate
DHS Demographic and Health Survey
DMPA Depo-Provera
FHI Family Health International
FISA Local IPPF Affiliate
FP Family planning
GoM Government of Madagascar
HIV Human immunodeficiency virus
IEC Information, education, and communication
IUD Intrauterine device
LAPMs Long-Acting and Permanent Methods
MCH Maternal and child health
MEC {WHO's) Medical Eligibility Criteria
MMR Maternal mortality ratio
NGO Nongovernmental organization
OCP Oral contraceptive pill
RH Reproductive health
SDM Standard Days Method
SPR Selected Practice Recommendations
STI Sexually transmitted infection
UNFPA United Nations Population Fund
US United States
USAID United States Agency for International Development
WHO World Health Organization

Executive Summary

This report documents the findings of a mission to assess the potential for introduction of evidence-based family planning practices in Madagascar. This assessment carried out during March and April of 2006, by a multidisciplinary team assembled and coordinated by Family Health International with technical and financial support from the United States Agency for International Development. This assessment was designed to identify strengths, prioritize problems, and work with community, governmental, and nongovernmental stakeholders in order to develop recommendations for ways to improve the uptake and use of evidence-based practices in family planning in order to strengthen the reproductive health service delivery system in Madagascar.

The assessment process consisted of a desk review of available materials and a two week visit to Madagascar by the assessment team. During the two week visit, the team met with representatives from agencies involved in provision of reproductive health services in Madagascar and visited multiple clinic and community outreach sites in Antananarivo, Andasibe, Antsirabe and Fort Dauphin. During visit to agencies and service sites, interviews were conducted to gather information about the context of services, use of specific evidence-based practices that could strengthen service delivery, and factors that might affect introduction and sustained use of any recommended practice(s).

The needs assessment visit revealed that incorporation of certain evidence-based practices could strengthen the RH service delivery system in Madagascar. The specific recommendations made by the team were mindful of two facts:

- Successful change is a process that requires communication regarding an innovation among members of a structured social system over an extended period of time.

- Research has shown that the success of efforts to promote adoption and sustained use of an innovation can be significantly influenced by perceptions of the innovation, characteristics of the adopters, and by a variety of contextual factors, such as leadership, management and the features of the practice environment.

Recommendations of the team were also considered in the light of feasibility and selected on the basis of safety, effectiveness, demonstrated success in other settings, low cost, potential for acceptability by clients and providers, and ability to implement without major additional investments in equipment and/or infrastructure.

The team's specific recommendations were as follows:

- Madagascar's Norms and Standards for provision of contraception should be updated to remove the menstrual requirement and use of the pregnancy checklist should be introduced at both the clinic and community health worker levels as a means of removing a medical barrier and improving access to contraception.

- Injectable contraceptives should be included among those methods offered by community outreach workers as a way of increasing access to a popular method.

- The Standard Days Method (SDM) should be included and supported at all levels of the RH system in Madagascar as a way of increasing the number of contraceptive options available, particularly to women who may not seek services at a clinic.

- Materials considered for use in orienting and implementing upcoming changes in practices should be based on the most recent WHO Medical Eligibility Criteria and Selected Practice Recommendations. In particular the team endorsed introduction of two jobs aids, the Combined Oral Contraceptive (COC) checklist and the Depo-Provera (DMPA) Checklist, to assist doctors, nurses, pharmacists, and community agents providing hormonal contraceptives.

- Appropriate providers should be updated on the most recent WHO Medical Eligibility Criteria and Selected Practice Recommendations related to provision of long acting and permanent methods, like the IUD and vasectomy

- The evidence-based practice known as "Systematic Screening" should be introduced as a way to increase uptake of priority services (e.g. family planning, safe motherhood, vaccination) and improve the efficiency clinic-based services.

Madagascar faces significant challenges as it struggles to improve the health of its citizens, build its economy, and protect its environment. Considerable foundational work has already been done to improve access to and quality of reproductive health services in Madagascar and the conditions, both policy and operational, are in place to capitalize on these investments. Introduction of the recommended evidence-based practices – simple, safe, low cost, and effective – will help the GoM to achieve it's goals, specifically lowering maternal morbidity and mortality, repositioning family planning, and achieving a contraceptive prevalence rate of 28% by 2009.

INTRODUCTION

This report documents the findings of a mission to assess the potential for introduction of evidence-based family planning practices in Madagascar. This assessment carried out by a multidisciplinary team assembled and coordinated by Family Health International with technical and financial support from the United States Agency for International Development. This assessment was designed to identify strengths, prioritize problems, and work with community, governmental, and nongovernmental stakeholders in order to develop recommendations for ways to improve the uptake and use of evidence-based practices in family planning in order to strengthen the reproductive health service delivery system in Madagascar.

BACKGROUND

The Government of Madagascar's (GoM) interest in finding, adapting and introducing evidence-based practices to strengthen family planning services is a direct result of its tangible commitment towards improving the reproductive health of its citizenry. Family planning is a key element of the GoM plan for development. During the last few years the GoM has provided a unified vision through its adoption of a National Family Planning Strategy, organized an Executive Secretariat for Family Planning within the Office of the President, increased the level of financial resources available to support family planning efforts, broadened the method mix from four to six contraceptive methods, and embraced a multi-sectoral approach to providing family planning services, notably though collaboration between the health and environmental sectors.

The public sector health system of the Republic of Madagascar serves the majority of the poorest and most disadvantaged members of the population. Public sector, reproductive health service delivery programs are conducted by the Ministry of Health and Family Planning, often with the support of external donors. For example, USAID supports a bi-lateral program (SanteNet) to support both public and private sector reproductive health services in Madagascar. Recently the public-sector programs have undergone scrutiny, and the country has initiated a process to update its reproductive health norms and developed new models for delivering reproductive health products and services. This overall reform includes the decentralization of management to the newly created administrative regions, districts and municipalities.

According to the most recent Demographic and Health Survey (1), the total fertility rate in Madagascar is high, estimated at 5.2 births/woman. The contraceptive prevalence rate is low at 27% overall and 18% for modern methods (married women). The contraceptive mix however, is skewed toward hormonal methods at least in part due to significant challenges in providing physical access to services. The pattern of childbearing is early sexual debut, early union, early first birth, little use of spacing methods, and large family sizes. Maternal mortality is also high at 469/100,000. Infant mortality is more moderate and has been trending downwards, with the most recent point estimate at 58/1,000. HIV prevalence is low, estimated at 1.7% in 2003 (2) but could be challenged in the near

future by increases in populations of core transmitters, especially participants in a burgeoning commercial sex trade, and a growing population of injection drugs users. Use of barrier contraceptives for family planning purposes is very low, estimated at 1.1% (1) despite recent efforts by the government of Madagascar and Non-Governmental Organizations (NGOs) to make condoms widely and cheaply available. Forty-seven percent of the total population of Madagascar is under the age of 15 (1), highlighting the need for health information and services as these young people become sexually active and begin family development.

NEEDS ASSESSMENT TEAM COMPOSITION

Composition of the team took into account the need for both institutional representation and adequacy of the collective skill set. In addition to representing FHI's Headquarters, Dr. Smith brought perspectives in health behavior, research utilization, and maternal health to the team. Dr. Ngom, familiar with the capacity of FHI Nairobi to support technical assistance in the region, brought perspectives in Demography and evaluation of community programs, and similar assessment experience in Francophone Africa. Ms. Warnick, representing USAID/Washington, brought expertise in research utilization and social marketing. Dr. Gaby, representing a faith-based NGO that is a participating member of SanteNet brought a medical perspective and knowledge of how programs are operationalized at the local level and Dr. Eugenie, representing the MOH&FP, brought both her specialized medical background in reproductive health and her national perspectives on program management. Though and ex officio member of the team, Dr. Benjamin Andriamitantsoa of USAID/Madagascar provided valuable insights on the donor's perspective and national policy level initiatives.

PROCESS AND TIMELINE

Tool development

In February and March of 2006, FHI took the lead in developing an overall strategy for the assessing health sector services in FP, as well as a qualitative tool designed to assist team members to conduct qualitative interviews with a variety of respondent types [policy makers, program managers, service providers and clients] they might encounter during the needs assessment visit. The strategy and tool were developed in collaboration with USAID/Washington and several other Cooperating Agencies (the Population Council, EngenderHealth, ADRA, the Academy for Educational Development, and the Institute for Reproductive Health at Georgetown University), however final responsibility for the quality of the instrument rests with FHI.

Desk Review

Desk review was conducted at FHI, between early February and mid March 2006. This review drew on available materials for a wide variety of sources and broadly covered two topic areas: 1) the context of reproductive health service delivery in Madagascar and 2) assemblage of documentary support for the evidence-based practices suitable for

recommendation under this activity. The list of practices and other criteria for selection can be found in Appendix 1. FHI staff also reviewed the current Norms and Guidelines governing provision of reproductive health services in Madagascar and made recommendations about modifications based on our understanding of the most current WHO Medical Eligibility Criteria (MEC) and Selected Practice Recommendations (SPR).

The Needs Assessment Visit

The needs assessment visit, and consequently all in-country data collection and synthesis, occurred March 27 and April 7, 2006. The early days of the assessment visit were dedicated to team building, orientation of stakeholders to the Mission, including an initial stakeholders' orientation meeting, and individual visits with key agencies who could provide background helpful during site visits. The itinerary for the visit can be found in Appendix 2.

In addition to visits conducted in Antananarivo, the assessment team visited facilities in three geographic sites, Andasibe, Antsirabe and Fort Dauphin. Please see Appendix 3 for a detailed list of facilities and contacts.

On April 6, 2006, the needs assessment team presented its observations and recommendations to an assembled group, comprised of representatives from a broad array of agencies with interest in the results of the assessment visit. For an agenda, see Appendix 4-A. For a list of attendees see Appendix 4-B. Preparation of the findings was a participatory process involving all team members and the findings represent a consensus of the needs assessment team.

In general, the assembled stakeholders endorsed the finding of the needs assessment team and, through discussion and a structured small group exercise, added commentary and guidance to supplement the team's recommendations. For a summary of results from the small group exercise, see Appendix 4-C.

Preparation of the Final Report

Preparation of this report the report took place between April 8 and April 30, FHI took primary responsibility for generating report drafts and circulating the drafts to team members for review. While input from all team members was solicited and incorporated, final responsibility for the contents of this report, and consequently and errors or omissions, rest with FHI.

FINDINGS

Level 1 - Policy and Environment

There were a number of system strengths at this level that were noted by the team. As already noted in the Background section, above, there is considerable high level political support for improving reproductive health in Madagascar. Family planning is s critical element of Madagascar's development strategy and the GoM is committed to expanded access to quality, voluntary family planning services as a means to achieve both its social equity and fertility management goals. At a practical level, the team found that political engagement regarding reproductive health services translated into a positive environment for improvements in both policy and operations. The existence of a broad-based working group for family planning provided a useful vehicle for converting the current political will for improvement into tangible progress on the ground. Considerable work had already been done on the development of strategies for improving reproductive health services with a focus on realizing immediate public health impact while building the base necessary for improving systemic performance of the service delivery system over time. Norms and standards guiding delivery of RH services were already under review at the time of the needs assessment visit. In this regard, the assessment visit was timely and input from the assessment can be considered by the stakeholder group charged with updating norms and standards to fully reflect recent changes to the WHO MEC/SPR. Strategies for supporting communications among service delivery program elements at a regional level were in evidence and hopefully these communication structures can be leveraged to support introduction and maintenance of evidence-based practices recommended by the needs assessment team. Improvement of the health management information system was underway at the time of the assessment visit. Finally, a reasonably broad range of methods was already being supported by the service delivery system at a policy and environmental level.

Opportunities for improvement identified by the assessment team at this level include the completion of the process of updating the norms and standards and, additionally, the broad dissemination of the new norms and standards and orientation of RH service delivery staff throughout the system to ensure understanding of the changes. Though considerable work had been done at a strategic level regarding improvements in the service delivery, communications and health management information systems, these strategies are nascent and operationalization will require considerable, persistent effort over the next few years. In the future, as research continues to document improvements in RH technologies and practices, the GoM will face the need for an ongoing process of systematic review and updating of its Norms and Standards in order to stay current with international service provision standards.

Level 2 – Health Clinic Services

During the needs assessment visit, the team had the opportunity to make observations and conduct interviews at a number of urban and peri-urban facilities categorized as CSB-2. Unfortunately, the team did not have the opportunity to visit FP services based in district or referral hospitals. Consequently, finding at this level are narrowly applicable to CSB-2 clinics, although by implication some recommendations may also be applicable to CSB-1 facilities.

At this level, strengths identified by the team included efforts to increase the number of functioning RH service delivery sites and training to expand the capacity of clinic personnel to deliver family planning products and services. Other strengths identified at the clinic level include improved availability of contraceptive commodities, the initiation of a Quality Improvement mechanisms in the system (e.g., APQ), and installation of a quarterly review mechanism for RH/FP services.

A pressing opportunity for improvement at the clinic level identified by the assessment team was the need to augment the capacity of clinic personnel to provide RH services. Specifically, this would involve improving orientation on Madagascar's Norms and Standards for service provision, especially important once updating of the Norms and Standards to reflect the current WHO MEC/SPR is completed.

A second opportunity involves encouragement of service providers to inform clients about the full range of contraceptive methods, including methods like long acting and permanent methods (LAPMs) that may not be available at a particular service site, but which are available elsewhere in the service delivery system.

A third opportunity for improving the capability of clinic-based providers had to do with the proactive offer of integrated services to maximize the efficiency of each clinic visit as well as health service productivity. A relatively large proportion of the population has poor access to clinic services and visits to a facility are costly to clients of limited means in terms of time and effort, resulting in many unmet needs for FP and MCH services. Ensuring the offer of multiple priority services (e.g., FP, child vaccination and STI diagnosis and treatment) to each client at each visit, at least in clinics with the capacity to provide services, would increase uptake of priority interventions and increase the efficiency of clinic visits.

Other opportunities for improvement at the clinic level included strengthening mechanisms for circulating program-related information throughout the system, continuing efforts to prevent stockouts of family planning commodities (and other consumable commodities), and providing additional supports to both IE&C activities and HMIS functions. And finally, overall strengthening of the RH supervision system would be a significant step in institutionalizing change, both to consolidate gains already made and to solidify any changes that might be forthcoming.

Level 3 – Community Outreach Services

Community outreach services had already been identified as a priority for improving access to RH services in Madagascar and the needs assessment team's findings concur with this view. Strengths at the community level observed by the team include a functional system of community agents using a uniform curriculum for training. Broad involvement of NGOs, some with overlapping but also some with unique functions, was seen as a strength in ensuring systemic capacity and reaching a diverse set of target populations. For example, PSI's efforts at Social Marketing seem to both complement and backstop public sector efforts to educate and inform the population regarding RH

products and services, as well as to strengthen systemic contraceptive security. Observations led the team to think that SanteNet's Champion Commune initiative, though still a work in progress, was functioning well for its stage of development and had potential as a program model for national level implementation. It has led to an improvement in resources available to CBD networks and a multi-sectoral approach that engages the community on issues such as linkages between family planning and the environment. The fact that promotion of at least some services, (e.g. FP and MCH) was integrated at the community level was seen as a strength by the needs assessment team. Finally, the base of volunteers that has been built up to support community outreach was seen by the team as having potential to support broader RH service delivery going forward.

As encouraging as some aspects of the community level service system were, there were also opportunities for improvement:

- There was significant concern about the capacity of community outreach workers. The uniformity of quality, both with content of counseling and the ability to respond to client needs, seemed variable. Some variation among individuals is to be expected, but given a uniform training structure, variability by agency and by site should raise a note of caution.

- Similarly, overloading community outreach workers, especially volunteers, is easy to do. Expectations of increased responsibility and improved performance of community outreach workers (such as those implied by integration of services) will need to be supported by improved training, supervision and eventually performance incentives if Madagascar is to achieve a sustainable community outreach program at scale in the future.

- The relationship between the community outreach workers and the service delivery clinics in their local area also seemed variable by agency and site. Ensuring strong relationships between the clinics and the outreach workers has potential as an approach to strengthening services across both levels and mechanisms for increasing the involvement of local service delivery points in training and supervision for community outreach workers deserve further exploration.

- Finally, the team observed that community outreach workers in some programs/sites had fewer tools (e.g. health education materials and job aids) to help them be successful in their jobs, than were available to workers in other programs/sites. This problem would seem to be relatively easy to remediate given that the materials exist and could be built into upcoming efforts to improve the quality and uniformity of training at this level.

RECOMMENDATIONS

Introducing evidence-based practices into an on-going service delivery system requires people to change their behavior. Typically they need to stop doing things the way they were doing them, learn something new, believe in its value, believe they can implement the change, and then figure out how to incorporate and sustain the innovation in their daily lives. Successful change is a process that requires communication regarding an innovation among members of a structured social system over an extended period of time. Research has shown that the success of efforts to promote adoption and sustained use of an innovation can be significantly influenced by perceptions of the innovation, characteristics of the adopters, and by a variety of contextual factors, such as leadership, management and the features of the practice environment. Introducing evidence-based practices into a RH service delivery system typically involve multiple adopter audiences (e.g. policy makers, program managers, service providers and clients), each with its own concerns and each with the potential to facilitate or impede progress.

There are many potential evidence-based practices only some of which are suitable for recommendation under this activity. Specifically, endorsed practices were to be:

- Safe
- Effective
- Evidence-based (demonstrated success)
- Low Cost
- Acceptable
- Not requiring major equipment/infrastructure investment

Of the possible candidates (see Appendix 1), practices actually recommended by the needs assessment team for implementation in Madagascar are those which match the specific needs of the program in Madagascar, taking into consideration stage of development, existing infrastructure, ongoing and planned activities, and perceived value by in-country stakeholders charged with implementation.

Reducing barriers to access to contraceptives

The standard practice for providing contraception in Madagascar requires that women be menstruating at the time of initiating use of a contraceptive method. International research has shown that in developing countries requiring menses as a condition for initiation of contraception poses a significant barrier to use. Research has also shown that up to 20% of women seeking contraception may be refused a contraceptive method because without menses the provider isn't sure whether the woman is currently pregnant or not. However, international research has validated a method for determining whether or not a non-menstruating woman is currently pregnant by asking a short and simple series of questions (3). These questions formed the basis for construction of a job aid commonly referred to as "The Pregnancy Checklist". This job aid has been validated through research as being 99% effective in detecting pregnancy among non-menstruating women seeking contraception. Use of these questions to determine eligibility for contraceptive provision is recommended by the *2004 Medical Eligibility Criteria for Contraceptive Use* published by the WHO.

The team's recommendation therefore is that Madagascar adjust its Norms and Standards for provision of contraception to remove the menstrual requirement and to introduce use of the pregnancy checklist at both the clinic and community health worker levels as a means of removing a medical barrier and improving access to contraception. Adjusting the Norms and Standards will reduce the proportion of non-menstruating women refused contraception at their clinic initiation visit. Perhaps more importantly, it will allow community outreach workers to initiate provision of contraception to their clients without first requiring an assessment by a clinic-based provider.

Broadening the range of available contraceptive methods

At current levels of fertility, the population of Madagascar will double in less than 20 years. Current levels of contraceptive use are relatively low and the level of unmet need for contraception in Madagascar is almost 25% (1). Research has shown that increasing the range of contraceptive options has been associated with increases in the level of contraceptive prevalence. In multinational research, the level of contraceptive prevalence has been shown to increase approximately 12% each time a new method is added in a manner that affords convenient access (4)

The first step recommended by the team is to include injectable contraceptives among those methods offered by community outreach workers. This action is one that increases access to a method already endorsed within the RH system in Madagascar by authorizing distribution via a new cadre of provider. Injectable contraception is the most popular method in Madagascar and increased availability through community-based services will likely result in immediate and significant increase in the contraceptive prevalence Rate (CPR).

The second step recommended by the needs assessment team, is for the Standard Days Method (SDM) to be included and supported at all levels of the RH system in Madagascar. The SDM, which requires only an understanding of the menstrual cycle and a memory aid (e.g., CycleBeads), has potential to be appealing to a population of women who, for whatever reason, do not wish to use other methods that involve hormones or devices. A successful pilot of the SDM has just been conducted in Madagascar and the results of this pilot are available to inform inclusion of this method at scale. Research from other countries has demonstrated that SDM using CycleBeads has been successfully provided through community outreach workers (5); therefore the team recommends offering this method though existing FP CBD workers in order to reach women that may not seek contraception at clinics.

Improving effective use of tools and procedures for providing contraception, based on the most current international norms and standards

The most recent version of the WHO MEC/SPR contain a number of updates and improvements over the previous version that formed the basis for the Norms and Standards that guide RH service provision in Madagascar today. Once Madagascar's

Norms and Standards for provision of RH services have been updated to reflect the most current MEC/SPR, service providers throughout the system will need sensitization and orientation to the changes in practice that the updating implies.

Various training and job aids have been developed based on the most recent WHO MEC/SPR and the **team recommends that these materials be considered for use in orienting and implementing upcoming changes in practices.**

Two job aids in particular, known as the Combined Oral Contraceptive (COC) checklist and the Depo-Provera (DMPA) Checklist, both based on the current WHO MEC/SPR are available to assist doctors, nurses, pharmacists, and community agents providing hormonal contraceptives. Designed to be complementary to the "Pregnancy Checklist" (see Reducing barriers to access to contraceptives, above), these aids are intended to guide provider through a protocol based on the most up to date international standards of practice.

Additionally**, the team recommends orienting providers on the most recent WHO MEC/SPR updates related to provision of long acting and permanent methods, like the IUD and vasectomy.** Over the last two years, considerable effort has been devoted to a multi-agency effort to assemble tools and information helpful to programs interested in increasing the role of IUDs in their family planning program. The "IUD Toolkit", as it is known, is a resource available to help with orientation and implementation of service providers and program staff. While no similar integrated resource exists for vasectomy, a number of evidence-based practices are now being recommended and should be included in orientation and training for vasectomy providers.

Improving the provision of integrated services at the clinic level.

During the needs assessment visit the team's observation was that at least some priority services (family planning, diagnosis and treatment of sexually transmitted diseases, vaccination, and delivery) were underutilized. This finding is supported by the most recent DHS which reports that 23% of women not using a family planning method did not discuss use of family planning on their last visit to a health service point. International research (6) has shown that systematic offer of multiple existing services can increase the uptake of services and increase the efficiency of clinic visits. In the research studies where family planning and safe motherhood services were included, utilization of these services improved by approximately 20% when multiple services were systematically offered to each client. This technique ultimately helps to reduce the unmet need for family planning, maternal, and child services at the community level.

The team's recommendation is that Madagascar introduce the evidence-based practice known as "Systematic Screening" into the way clinic-based services are offered. "Systematic Screening" is an intervention where providers follow an algorithm to screen clients for several health service needs, in addition to the specific service initially prompted the client to seek services at the clinic. The technique, supported with and implementation manual and job aid, can be introduced into clinics that have enough

capacity to support the increased provision of services and adapted at sub-national levels to reflect the service needs and priorities of the clinics where it is being implemented.

CONCLUSION

Madagascar faces significant challenges as it struggles to improve the health of its citizens, build its economy, and protect its environment. Considerable foundational work has already been done to improve access to and quality of reproductive health services in Madagascar and the conditions, both policy and operational, are in place to capitalize on these investments. Introduction of the recommended evidence-based practices – simple, safe, low cost, and effective – will help the GoM to achieve it's goals, specifically lowering maternal morbidity and mortality, repositioning family planning, and achieving a contraceptive prevalence rate of 28% by 2009.

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APPENDIX 1 - List of Evidence-Bases Practices and Criteria for Selection

List of Evidence-based Practices for Consideration

I. Improving effectiveness of community outreach in family planning:

The presence of health facilities is limited in rural settings in much of Africa. Community outreach, especially making contraceptives available through community based distributors (CBD) is an approach that has successfully accelerated the access and use of contraceptives in community settings. CBD of a variety of contraceptives is safe and effective, and has been demonstrated successfully. Many CBD programs, might however be optimized by improving CBD screening techniques and making more methods available.

1. CBD of oral contraceptives
    a. Use COC/DMPA checklist
2. CBD of injectables
    a. Use COC/DMPA checklist
3. Make sure CBD programs are effectively distributing condoms, as appropriate
4. CBD of Standard Days Method
5. Increase male involvement in CBD settings
    a. Male distributors of contraceptives

II. Improving clinic-based family planning services, through tools, techniques and service organization

Several tools and techniques have been developed to improve access to contraception in clinic settings. These tools and techniques help the provider to perform better, enable front line providers to effectively increase access to contraception, and meet the unmet need for maternal and child health services. By adopting these approaches, programs have increased contraceptive use by new groups of clients, and increased method continuation among hormonal contraceptive clients.

1. Use a systematic screening technique to meet the unmet need for a variety of FP/MCH services
2. Improve Access and Use of Hormonal Contraception
    a. Using checklists to improve client screening
        i. Pregnancy checklist
        ii. DMPA/COC checklist
        iii. IUD checklist
3. Improve provision of hormonal contraceptives through four easy practices:
    a. Quick Start
    b. Advance Provision
    c. Improve counseling on new WHO instructions on missed pills
    d. Improve provider awareness of DMPA Injectable grace periods

4. Broaden the method mix by adding new or underutilized methods to existing clinic-based programs:
    a. Condoms for dual protection
    b. Standard Days Method
    c. LAM
    d. Emergency Contraception
    e. Referrals for LAPM
5. Improve contraceptive use by Increasing Male Involvement in maternity care settings.
    a. Antenatal
    b. Postpartum

III. Improving the provision of Long Acting and Permanent Methods – (for programs with existing capability to provide LAPM and sufficient demand). Where IUD insertions and Vasectomies are taking place, good programming practices are available which can broaden the range of clients to which these methods can be offered, reduce the costs of service, remove barriers to access, improve acceptability, and reduce method failure.

1. Improve Provision of IUDs:
    a. Provide IUDs to nulliparous women
    b. Provide IUDs as an option for HIV-positive women (if setting supports thorough counseling and continuing access to services)
    c. Eliminate provision of prophylactic antibiotics before IUD insertion
    d. Reduce follow-up visits to one

2. Improve Provision of Vasectomy Services:
    a. Fascial interposition
    b. Cautery
    c. No scalpel
    d. Post-vasectomy counseling

Criteria for Selecting these Best Practices

There are many potential best practices. This project proposes to limit the range of supported best practices to a few that are well validated, low cost, relatively easy to implement, and that have a high probability of adding value to an existing program. The criteria for selecting the range of evidence-based practices suitable for consideration under this activity are:

- Safe
- Effective
- Evidence-based (demonstrated success)
- Low Cost
- Acceptable
- Not requiring major equipment/infrastructure investment

APPENDIX 2 – Itinerary for Needs Assessment Visit

PROGRAMME DE L'EQUIPE Family Health International (FHI) A MADAGASCAR

24 mars au 06 avril 2006

DATE	TIME	ACTIVITES	LIEU	CONTACT
Vendredi 24 mars	22:50	Arrivee a Tana (J. Smith et E.Warnick)		Hotel Colbert 22 202 02
Samedi 25 mars	21:30	Arrivee a Tana (P. Ngom)		Hotel Colbert 22 202 02
Dimanche 26 mars		Visite du Palais d'Ambohimanga (Smith, Warnick, Ngom)		
Lundi 27 mars	08:30	Team Building (FHI, MOH/PF: Dr Perline, Dr Bako, Dr Eugenie, USAID:Benjamin/Wendy, Paul Blumenthal, SANTENET: Dr Serge, Volkan Cakir, Dr Gaby, Viviane	Hotel Colbert	Dr Gaby @ 032 07 226 78 Viviane 032 02 661 62
	11:00	Visite de courtoisie auprès du MOH	MOH Ambohidahy	Dr Eugénie @ 032 04 726 95
	14:30	Briefing USAID	Immeuble ZITAL Ankorondrano	

Mardi 28 mars	09:00 11:30 14:30	Réunion/présentation avec le MOH/FP et les partenaires : ADRA, CARE, MCDI, Plateforme religieuse, PSI, SAF/FJKM, SALFA, SanteNet, USAID, Penser. Visite FISA Départ pour Andasibe	Salle de conférence MOH/FP – Ambohidahy Ambatomitsangana Hotel VAKONA	Dr Eugenie @ 032 04 726 95 Dr Gaby @ 032 07 226 78 Viviane 032 02 661 62 Mlle Lova @ 22 624 80
Mercredi 29 mars		Visite Réserve d'Andasibe Visite sites SAF/FJKM et ADRA	Andasibe Andasibe	
Jeudi 30 mars	08 :00	Départ pour Moramanga Visite SSD et PHAGEDIS Retour sur Tana		Dr Eugenie @ 032 04 726 95 Dr Gaby @ 032 07 226 78 Viviane 032 02 661 62
Vendredi 31 mars	08 :00	Descente Antsirabe Mandrosohasina : PHAGECOM Antsohantany : CSB, AC	Hotel ANTSAHA	@ 44 050 02
Samedi 01 avril		Retour sur Tana		
Dimanche 02 avril				
Lundi 03 avril	06 :30	Départ pour Fort-Dauphin MD700/742 @ 07 :50 Arr. : 11 :30 (Benja Andriamitantsoa, Jason Smith, E. Warnick, P.Ngom, Dr Perline Rahantanrina , Dr Eugenie Rasamihajamanana, Dr Gaby	Hotel le Dauphin	@ 92 212 38

		Rakotondrabe, Viviane Rakotovazaha) Visite « Communes Mendrika »		
Mardi 04 avril	08 :30	Visite Top Réseau , APQ, CSB		Mrs Kelsey M. Andry (Santenet) @ 92 210 23
Mercredi 05 avril	10 :00	Retour sur Tana MD713 @ 11 :55 – Arr. : 14 :15 Préparation de la réunion du lendemain		
Jeudi 06 avril	09 :00	Réunion de partage sur l'évaluation des meilleures pratiques en PF le MOH/FP et les partenaires : ADRA, CARE, MCDI, Plateforme religieuse, PSI, SAF/FJKM, SALFA, SanteNet, USAID, Penser	Restaurant ASTAURIA Antanimena	

APPENDIX 3 - List of Contacts

Personnes Contactées

Equipe:

Dr. Eugenie Rasamihajamnana	Direction de la Sante de la Famille
Dr. Gaby Rakotondrabe	ADRA
Viviane Rakotovazaha	Consultant
Dr. Lalasoa Rasetriarivony	SR-MSR Direction de la Sante de la Famille
Jason Smith	FHI, USA
Pierre Ngom	FHI, Kenya
Elizabeth Warnick	USAID, Washington

Contacts :

Antanarivo

Dr. Jean Louis Robinson	Ministere de la Sante
Dr. Perline Rahantanirina	Directeur, Direction de la Sante de Famille
Dr. Bako	Directeur, Service de la Sante de la Reproduction
Autres Representants	Direction de la Sante de la Famille
Phillippe LeMay	Directeur, SanteNet
Volcan Cakir	Directeur des Programmes, Sante Net
Benjamin Andriamitansantsoa	USAID
Wendy Benazerga	USAID
Paul Blumenthal	JHU/CCP (USAID FP Advisor)
Volonirarainy Rajohns,	FISA (IPPF) President Regionale
Mbola Andriatsimba,	FISA (IPPF) Coordinateur Regionale

MoroManga/Andasibe Region

Commune de Ampasimpotsy	
Mme Noela	ADRA, Commune Ampasimpotsy
Mr. Henry Germain Rabenarivo	ADRA, Commune Ampasimpotsy
OJO ???NOM	Inspecteur du District, Moramanga
OJO ???NOM	PHAGEDIS
Dr. Fanja Harijato Andrianaitovo	FJKM/SAF Chef D'Unite, Moramanga
Justin **OJO ????**	FJKM. Commune Championne

Antsirabe Region

Berthine Rasoarimalala	Aide Sanitaire, CSB, Mandrosohasira
Marie Julienne Rahiliarisoa	Animatrice, Mandrosohasira
John Razafimanjato	Directeur Regional de Santé, Antsirabe
Norohanta Verosniana Andriatsimametra	Responsable de SR
Jacky Razakadera	Chef SMS
Dr. Hanita Razairinoro	Resp., Clinique FISA, Antsirabé
Mme. Nany Rahrimalala	Resp. IEC, FISA, Antsirabé

Ft. Dauphin

Dr. Lucie Ramanandraibe	Directeur Regional de Sante, Ft. Dauphin
Dr. Josiane Ramangason	Medecin, Top Reseau, Ft. Dauphin
Dr. Jean Rasolofoaritianana	Medecin, CSB, Bazaribe
Dr. Josiane	Medecin Inspecteur du District Bazaribe
Dr. Bakoly Rantoanina	PSI, Ft. Dauphin
Dr. Harninesy Rajeriharindranto	ASOS
Dr. Bosco Bezaka	SanteNet
Kelsy Lynd	Peace Corps/SanteNet
Andry Raherimamiandra	SanteNet

APPENDIX 4-A

Réunion du 6 avril
Mission d'évaluation des bonnes pratiques en planification familiale

9 :00 Introduction – Ministère de la Santé et de la PF

9 :10 Ouverture de la réunion – Ministère de la Santé et de la PF

9 :20 Objectifs et agenda de la réunion – Dr. Eugénie
Objectifs de la Mission et méthodes – Dr. Eugénie

9 :30 Principales observations de la Mission – Dr. Gaby

10 :00 Pause

10 15 Recommandations de la Mission – Pierre & Elizabeth

10 :45 Discussion : Questions/Réponses – Dr. Gaby

11 :00 Travaux de groupes :
1) Services communautaires - Elizabeth
2) Services cliniques - Dr. Gaby
3) Politique et environnement – Dr. Eugénie
4) Suivi et Evaluation – Jason & Pierre

12 :00 Présentation des recommandations des groupes - Elizabeth

12 :40 Clôture de la réunion – Ministère de la Santé et du Planning Familial

13 :00 Déjeûner

APPENDIX 4-B

List of people who attended the second stakeholders' meeting

Participants (Last/First)		**Institutional Affiliation**	
Randiranagolo, Bahaly		Marie Stopes International	
Razafindcovony, Bakoly		MOH&FP/Div FP	
Razanoelina, Nalimalala		IPPF	
Vololoutona, Tiame		DEP	
Rasoaharimalala, A.		SIECTIS	
Rakotonirina, L. Josette		DDDS	
Raketakandria, Nivohadu		MOH&FP/Safe Motherhood	
Raharimanana, Gertrude		MOH&FP/Safe Motherhood	
Cakir, Volkam		SanteNet	
Rakotonanga, Avotiang		SanteNet	
Rokotorima, Beko Mine		MOH&FP/Safe Motherhood	
Rafiringason, Rigobert		UNFPA	
Andriamitantsoa, Benjamin		USAID	
Rahantanirina, Perline		MoH&FP	
Feroldi, Julie		French Embassy	
Nasy, Harisoa		WHO	
Rakotobe, Andrianana		ARTEL	
Rakotondramboa, Sandra		National HIV/AIDS Committee	

Rahajarison, Andry		PSI	
Blumenthal, Paul D		JHUCCP/USAID	
Rokotovao, Jean			
Team			
Rakotondrabe, Gaby		ADRA	
Rasamihatamavana, Eugenie		MOH&FP	
Rasetriarivony, Lalasoa		MOH&FP/Safe Motherhood	
Smith, Jason		FHI/NC	
Ngom, Pierre		FHI/Kenya	
Warnick, Elizabeth		USAID/Washington	
Rakotovazaha, Viviane		Logistics Consultant	

APPENDIX 4-C

FP Best Practices in Madagascar - Dissemination Meeting
April 6th, 2006

RECOMMENDATIONS FROM WORKING GROUPS

Group 1 – Community Services

1. Train community health workers (CHW) on the correct utilization of the pregnancy checklist.
2. Pilot the implementation of the new checklist on a few selected sites before scaling it up.
3. Inform and sensitize communities on the new criteria for being eligible to get contraceptives.
4. Translate into Malagasy the pregnancy checklist.
5. Have a selection process for CHWs to qualify for the provision of injectables.
6. Generalize the provision of contraceptives by CHW to first time clients

Group 2 – Clinical Services

1. Reinforce counseling skills.
2. Provide up to 6 cycles of pills for first time clients.
3. Make all contraceptive methods available at all levels where these are supposed to be provided.
4. Carry out Operations Research on community based provision of injectables.
5. Improve integrated services in all health outlets

Group 3 – Policy Environment

1. Include the various checklists in the training (and refresher training) curriculum of health professionals.
2. After updating all norms and standards/MEC, plan for the operationalization of the community based distribution of injectables.
3. Disseminate the norms and standards/MEC at all ministerial levels and ensure that they are used at national, regional, district, and community levels.
4. Improve access to contraceptives by the poor through an adequate implementation of the Equity Fund.
5. Institutionalize a “Family Planning Ambassador” strategy.
6. Integrate FP into EPI outreach.

Group 4 – Monitoring and Evaluation

1. Set up an ad-hoc committee to integrate the monitoring and evaluation of the recommended best practices in the existing HMIS. Members of this committee will be from SSR-MSR, DDS, Services Statistiques Sanitaires (which is in charge of the HMIS), UNFPA, PSI, and Santé-Net. Technical assistance will be provided by FHI.

2. The proposed committee will develop M&E indicators for each of the best practices proposed by the Best Practices Team. In order not to over burden the health workers, there must be a maximum of two indicators per proposed best practice.
3. With respect to the M&E methodology, three pilot districts will be selected for the field testing of the new M&E tools. One of these districts will be a high performer, the second one will be an average performer, and the third one will be a low performer. Within each of these districts, three health outlets will be selected; one higher performer, one average performer and one low performer.
4. The scale up of the new M&E system will be implemented after completion of the evaluation of the pilot sites.